Estimated Date of Need:_____
Date Application Completed:_____

provisionCARES FOUNDATION

Financial Assistance Application

I. Applicant Information

Last Name_____ First _____Middle_____

Date of Birth (mm/dd/yy) _____ SSN _____Gender_____

Address _____ City_____ State_____ Zip Code_____

Phone (Home) _____ Phone (Mobile) _____ Email _____

If the patient is under the age of 21, please provide the name of the parent or guardian (and his/her relationship to the patient) completing this application: _____

Applicant diagnosis: _____

Estimated treatment dates: _____

Please provide any additional information that may be helpful in assessing your application._____

_____

_____

II. Grant Request

Contact at Medical Treatment Facility:_____
Define Patient Need: _____(hotel, transportation, etc.)
Dates of Need: _____

Patient Needs	**Dates**	**Estimate**	**Other Resources ACS/CIA/PC/Other* (circle all that apply)**	**Amount of Other Resources**	**Request for Provision CARES Foundation**
Housing		$	ACS/CIA/PC/Other	$	$
Transportation		$	ACS/CIA/PC/Other	$	$
Medical		$	ACS/CIA/PC/Other	$	$
Utilities		$	ACS/CIA/PC/Other	$	$
Other		$	ACS/CIA/PC/Other	$	$
TOTAL		$		$	$

*American Cancer Society (ACS), Compassion in Action (CIA) and Patient Contribution (PC)

Date Financial Assistance Needed: _____

Please provide an explanation of why you are applying for a Provision CARES Foundation grant. Use an additional sheet if necessary or if you would like to type this section.

_____

_____

_____

III. Medical Treatment Facility or Service Provider of Patient Needs (Use separate sheet for additional providers)

Organization Name_____

Address_____

City_____ State_____ Zip_____

Telephone Number_____

IV. Financial Information

Note to parents/guardians: All financial data should be based on your personal information.

Number of individuals in primary household (including patient): _____

Do you have any supplemental insurance that covers nonmedical expenses? (Yes/No) _____

How many miles is the provider from your home?_____

Expected duration of treatment: _____ days

How much do you currently have in ALL checking, savings accounts including CDs, IRAs, 401K, etc.?

List account type	Current Balance
1.	$
2.	$
3.	$
4.	$
5.	$

- Please submit copies of the last two months' statements for all accounts

Please tell us about your current HOUSEHOLD job(s) and income:

Employer:	Annual Income: $
Employer:	Annual Income: $
Social Security and/or Disability Benefits:	Annual Income: S
Other Income (ex: alimony, rental income, child support, etc.)	Annual Income: $

- Submit a copy of the previous two year's household income tax return (Form 1040 or similar)
- If you do not file taxes, please submit documentation of any household income.

Do you own real estate? If so, please describe any types of homes you own. (year purchased, price, what you owe on the home(s))_____

_____

_____

Please describe any liabilities you or your household owes. Examples may include home mortgage, automobiles, credit cards, healthcare, alimony, etc. Include the amount you owe.

List account type	Current Balance
1.	$
2.	$
3.	$
4.	$
5.	$

Please provide a list of incurred and expected costs for treatments (including bills for healthcare providers, if any).

List account type	Current Balance
1.	$
2.	$
3.	$
4.	$
5.	$

Please list all medical insurance companies, if any, that insure the patient and the coverage provided. _____

_____

_____

Applicant Checklist

The Provision CARES Foundation WILL NOT accept applications that do not include all of the following:

_____All 3 pages of the Provision CARES Foundation application

_____Patient Assistance Provider Acceptance Form completed by an authorized person

_____Copies of detailed statements showing transactions for all household bank accounts for the past 2 months

_____Copies of the previous two year's household income tax returns (Form 1040 or similar)

I hereby certify that the information provided in this application is true and correct to the best of my knowledge and agree to update my application if and when there are any changes to the information submitted.

_____ _____

Applicant Signature Print Name

_____

Date

Patient Assistance Provider Acceptance Form

In order to qualify for a patient assistance grant from the Provision CARES Foundation, an applicant must show that they have been accepted for treatment at a cancer treatment facility in the United States. The candidate must have this form completed by an authorized person (examples of an "authorized person" include, but are not limited to, a facility social worker, intake manager, nurse, or financial coordinator) at the cancer treatment center where they are about to begin or are currently being treated. Before returning this form to us, the applicant should make sure that they (or a guardian if the applicant is under the age 21) have signed the bottom.

Section to be completed by authorized cancer treatment facility representative

I_____(first and last name) in my capacity as a _____ (title) at _____ (name of facility) certify that _____ (applicant first and last name) is currently undergoing or is about to begin cancer treatment. The applicant has or will begin treatment on _____ (date) and is scheduled to conclude treatment on _____ (date).

_____

Signature of Authorized Facility Representative (date)

_____

Name of Authorized Facility Representative (please print)

_____

Facility Address

_____

Phone number

Section to be completed by grant applicant

I certify that the above information is correct and that I am receiving or about to undergo treatments at the facility listed above. I also consent to allow a representative from the Provision CARES Foundation to contact the authorized person at the facility at which I am receiving treatments in order to verify my eligibility.

_____

Patient Signature (or Guardian if the applicant is under the age 21)